

ADVISORY

Michigan Department of Health & Human Services

CERTIFICATE OF NEED
South Grand Building
333 S. Grand Avenue
Lansing, Michigan 48933
(517) 241-3344 -Fax (517) 241-2962

Amendment Review

MCL 2016(3)(d): The department shall charge a fee of \$500 to review any Letter of Intent requesting or resulting in a Waiver from Certificate of Need review and any Amendment request to an approved Certificate of Need.

APPROVED CON PROJECTS REQUIRING AMENDMENT REVIEW

1. Addition of covered clinical equipment short-term lease for a temporary mobile unit (CT, MRI)
2. Assignment of postal address *[amendment fee waived]*
3. Change from lease equipment to purchase equipment
4. Change from purchase equipment to lease equipment
5. Change make/model of CON approved covered clinical equipment [even at decreased project costs]
6. Change in approved project; [example: not implement all phases of construction project or change project to a phased project]
7. Change in source of funds
8. Construction project extension *[amendment fee waived]*
9. Covered clinical equipment installation extension *[amendment fee waived]*
10. Covered clinical equipment first procedure/first scan *[amendment fee waived]*
11. Increase lease term (space or equipment)
12. Increase project costs (above 15-10%)
13. Increase square footage (above 10%)
14. Reconfigure or change bed designation of acute care beds, NH beds or Hospital beds [example: # of private, # of semi-private, # of bed sub-categories], decrease of beds with a decrease of project cost & square footage. *An increase of beds cannot be amended.*

Amendment fee (\$500) must be submitted per MCL 2016(3)(d). An Amendment request will not be deemed received until the appropriate fee and supporting documents have been received. The Amendment will be processed, as required by the Administrative rules, once the Amendment fee is received by the Department.

Checks are to be made payable to: State of Michigan, and Certificate of Need (CON) is implementing a [new mail process](#) starting immediately. All payments (checks) must be mailed directly to the Cashier's Office at MDHHS Cashier Office, Suite 801, Certificate of Need, P.O. Box 30437, Lansing, MI 48933.

Please include the following information with the check in this format:

CON number XX-XXXX

Facility number XX-XXXX

Facility Name XXXXXX (If not on the check)

Payment for Application fee, Annual Survey, LOI, Fine/Settlement, etc.

Please send all payments (checks) to:

MDHHS Cashier Office, Suite 801

Certificate of Need

P.O. Box 30437

Lansing MI 48933

Please send all Applications and Electronic Documents to:

MDHHS-CONProjects@Michigan.Gov AND/OR

MDHHS Certificate of Need Evaluation Section

South Grand Building, 4th Floor

P.O. Box 30195

Lansing MI 48909

Pursuant to Administrative Rule 325.9413(5), "The review period for a request to amend an approved Certificate of Need shall not be longer than the original review period for the application."

The Department may revise the categories on this list at its discretion.

Revised 10/01/2022